DMAS CLIENT APPEALS
AUTHORIZED REPRESENTATIVE FORM

CLIENT'S NAME: _____DATE OF BIRTH#: _____

SSN: _____CASE NUMBER: _____

AREA CODE AND DAYTIME PHONE NUMBER: __(_____)_____

I WISH TO APPEAL THE DECISION OF _____ TO
Name of Agency

DENY, TERMINATE, OR REDUCE MY MEDICAID OR FAMIS BENEFITS. THE ACTION WAS TAKEN ON _____.
Date

I HEREBY APPOINT _____ AS MY AUTHORIZED REPRESENTATIVE TO ACT ON MY BEHALF DURING MY MEDICAID/FAMIS APPEAL.

MY REPRESENTATIVE'S ADDRESS IS: _____
_____

MY REPRESENTATIVE'S AREA CODE AND DAYTIME TELEPHONE NUMBER ARE _(_____)_____.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT IT IS STRICTLY VOLUNTARY.

I UNDERSTAND THAT MY SIGNATURE DOES NOT WAIVE MY RIGHT TO REPRESENT MYSELF.

I UNDERSTAND THAT MY SIGNATURE DOES NOT WAIVE MY FINANCIAL OBLIGATION SHOULD THE APPEAL BE DECIDED IN THE AGENCY'S FAVOR.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

_____
Print Name of Client/Client's Spouse/Parent of Minor Child

_____
Signature of Client/Client's Spouse/Parent of Minor Child

_____
Date

_____
Witness to Mark

_____
Date